BRIGHT LIGHT MEDICAL IMAGING

CT Screening Form

Today's Date _____ Referring Doctor _____

Name _____ DOB _____ Age_____ Wt _____

Your Symptoms/Reason for this Exam:

_____

_____

_____

_____

Surgical History _____

History of Cancer?_____

Have you had a CT before? NO YES (if yes, please detail below)

Type _____ Date _____ Location_____

Type _____ Date _____ Location_____

Type _____ Date _____ Location_____

Females:
Any chance of pregnancy? YES NO LMP _____

Have you ever been a smoker? YES NO

How many years? _____ If you quit, when? _____

Patient Signature _____ Date _____

Tech comments_____

_____

Reviewed by Tech (Signature)_____ Date_____

Translator_____